LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

4634

PLACE OF DEATH Grandy.
County Taylor
Township
City (No. St. Ward)
Registration District No. 333
Primary Registration District No. 5467
File No. 2
Registered No. 39

FULL NAME William D Mc.Clure.

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
th of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married.

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Susie.McClure.

ATE OF BIRTH (MONTH, DAY AND YEAR) July 2018 62

GE 60 YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	6	15	

CCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

IRTHPLACE (CITY OR TOWN) Missouri.
(STATE OR COUNTRY)

0. NAME OF FATHER William A McClure

1. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

2. MAIDEN NAME OF MOTHER Sarah J Ramsy.

3. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri.
(STATE OR COUNTRY)

INFORMANT Susie McClure
(Address) Princeton Mo

FILED Feb 8, 1923 L. S. Peery REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1923

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1922, to Feb. 4, 1923, that I last saw him alive on Feb 3, 1923, and that death occurred, on the date stated above, at 12 15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Cholecystitis
several (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Gastritis
several (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) C H Cullen, M. D
Feb. 5, 1923 (Address) Trenton, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Willis Chapel | DATE OF BURIAL Feb 5 1923

20. UNDERTAKER W D Haines | ADDRESS Gilman City

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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V. S. No. 2.

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....W

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT [illegible]
(Address) [illegible]

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17. I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,
that I last saw h..... alive on.....,19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL [illegible] — DATE OF BURIAL [illegible]

20. UNDERTAKER [illegible] — ADDRESS [illegible]